RWANDA AND HIV/AIDS

Key Talking Points

Rwanda is among the nine African countries hardest hit by the HIV/AIDS epidemic:

- About 13 percent of the adult population are infected with HIV.
- HIV prevalence rates range from 11 to 56 percent among high-risk groups.
- More than 370,000 Rwandans are living with HIV—180,000 of them with AIDS.

AIDS Deaths AIDS is one of three leading causes of death in Rwanda. It claimed 36,000 lives in 1997 and has already reduced life expectancy from 54 to 42 years.

Women and HIV/AIDS In 1997, 30 percent of pregnant women in urban Kigali antenatal clinics and 15 percent in other regions tested positive for HIV. A post-war survey found that many women had been raped, and that victims of rape were more likely to be infected with HIV.

Youth and HIV/AIDS In 1997 the estimated HIV prevalence among the sexually active population younger than 20 was almost 10 percent. Four percent of Rwandans ages 12 to 14 are already infected with HIV.

Children and HIV/AIDS Over the next 16 years, AIDS is expected to increase Rwanda's already high infant mortality rate of 130 deaths per 1,000 live births by 10 percent. At the end of 1997, Rwanda had 94,000 AIDS orphans.

Reconstruction and Development The HIV/AIDS epidemic will have a severe social and economic impact on a country already overburdened with debt and the bitter legacy of a genocidal civil war. Families struggling to survive will lose food and income as adults become too ill to work. Government services will be unable to meet the increasing need for care and support. And the loss of so many productive workers will slow efforts to rebuild and develop Rwanda's economy.

USAID was the first bilateral mission to resume programs in Rwanda in 1995. This prompt assistance made it possible to quickly launch HIV prevention activities throughout the country. USAID dedicated $1 million in FY 1997 to HIV/AIDS activities.

National Response HIV/AIDS is now considered a national priority. The government's health budget was increased by 23 percent in 1999, with an emphasis on HIV/AIDS. The national AIDS program has developed a strategic plan for 1999-2001 and a national HIV/AIDS prevention and communication strategy.

Despite this progress, Rwanda faces formidable challenges in responding to the epidemic. More immediate threats to health, including violence and inadequate access to housing, clean water, sanitation, and nutrition, make people more vulnerable to HIV and more fatalistic about their risk of infection. Continuing ethnic conflicts keep urgently needed health workers and HIV prevention programs out of war zones, and religious resistance makes it difficult to promote condom use.

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Country Profile

Rwanda is the most densely populated country in Africa. More than 90 percent of the population live in rural areas. Rwanda is also one of the poorest countries on the continent, with a gross domestic product (GDP) per capita of $250.

At the end of 1996, Rwanda's external debt stood at $1.1 billion, or 83 percent of the GDP. High debt service is affecting the country's ability to devote resources to health care. The post-genocide government, now in its fifth year of rule, is still struggling to rebuild a civil society, reintegrate hundreds of thousands of recently returned refugees, ensure food security, and provide basic public services. Extreme poverty, ethnic tensions and loss of human resources due to death and detention have multiplied Rwanda's development challenges. The World Bank estimates that Rwanda's GNP was more than halved in this decade, from $373 in 1990 to $179 in 1996.

The civil war completely destroyed Rwanda's extensive network of health centers and hospitals. Since the end of the war in July 1994, the government has received financial and technical support from the international community to rebuild its health infrastructure.

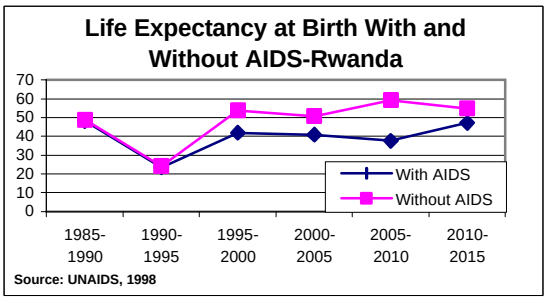
Overall health in Rwanda remains poor, with only 27 percent of Rwandans living within a one-hour walk of a health center. Infectious diseases—malaria, respiratory infections, HIV/AIDS and other sexually transmitted infections (STIs), and diarrhea—were the predominant cause of morbidity and mortality in 1998.

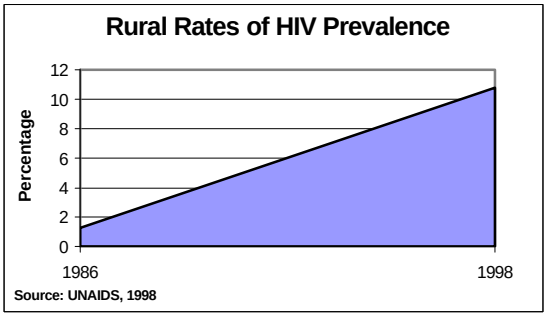
Rwanda is currently designing and implementing a comprehensive model of health reform. USAID is working with the Rwandan government to improve stability and increase human and physical capacity so that Rwanda can initiate effective sectoral reforms, implement major structural adjustment, and attract significant private sector investments.

HIV/AIDS in Rwanda

The Joint United Nations Programme on AIDS (UNAIDS) reports that Rwanda is already one of the nine African countries most severely affected by the epidemic:

- More than 370,000 Rwandans—almost 13 percent of the adult population—are living with HIV. About 180,000 of them have developed AIDS.
- HIV prevalence rates in urban areas range from 32 percent in low-risk groups to 56 percent in high-risk groups. Rural rates range from 10 percent in low-risk groups to 11 percent in high-risk groups.
- AIDS claimed 36,000 lives in 1997.
- AIDS is one of the three leading causes of death in Rwanda. By 2005, the crude death rate will be 40 percent higher due to AIDS than it was in 1990.
- Life expectancy has been reduced from 54 to 42 years as a result of AIDS.





- Data correlating HIV and TB in Rwanda are dated, but indicate rates ranging from 50% to nearly 95% of TB patients infected with HIV.

According to the Ministry of Health, the underlying causes of the epidemic are the economic crisis; high rates of multiple sex partners; the early onset of sexual activity; the presence of STIs; the availability of commercial sex; and resistance to talking about sex and using condoms.

Before the political turmoil of the mid-1990s, more studies had been conducted to understand the HIV epidemic in Rwanda than in most developing countries. The pattern of infection was a familiar one: high rates (more than 27 percent of pregnant women infected) in urban areas, but far lower rates (just over 1 percent) in the rural areas that were home to the bulk of the population.

The political turmoil in recent years changed the shape of the epidemic. A 1997 survey indicated that the gap between rural and urban HIV prevalence rates was closing. Rural rates soared from 1.3 percent in 1986 to nearly 11 percent in 1998.

Much of this shift in the epidemic can be ascribed to the huge population movements during and after the years of ethnic conflict. Nearly three-quarters of 4,700 Rwandans surveyed in 1997 had lived elsewhere in the preceding three years. Refugees who spent those years in countries with relatively strong prevention programs had lower rates of HIV infection than those who stayed in Rwanda. People who had lived in Rwandan refugee camps, however, endured overcrowding, violence, poverty, and despair—conditions that often led to rape or consensual but unprotected sex.

The social structure within the country has also changed in ways that threaten to exacerbate the HIV/AIDS epidemic. The war broke down social taboos against promiscuity, and the constant threat of violence has made it difficult to convince people of the severity of a disease that takes years to develop. Remaining members of decimated families search for companionship and opportunities to start new families. In some communities, the pre-colonial tradition of polygamy is being revived as many women who lost their husbands and sons in the fighting now share men in order to have more children.

HIV/AIDS and Women

- In 1997, 30 percent of pregnant women in urban Kigali antenatal clinics and 15% in other regions tested positive for HIV, compared to 10 percent in rural clinics
- Young women of childbearing age (15 to 24) are more likely to be infected than males in the same age group.
- Women with histories of STDs (genital sores) are much more likely to be HIV positive, 26%, than those with no such history, at only 10 percent seropositive.
- While 95% of prostitutes know the risks of HIV transmission, only 50% use condoms, due to objections of their customers.
- Seventy six percent of prostitutes tested are HIV positive.

In Rwanda, as in many other countries, women's low social and economic status, combined with greater biological susceptibility to HIV, put them at greater risk of infection. Deteriorating economic conditions, which make it difficult for women to access health and social services, compound this vulnerability.

Urban women are at much greater risk of HIV than rural. This trend is more consistent across age groups for women than for men.

Rape—inside or outside refugee camps—has no doubt played a part in spreading the virus in Rwanda. Some 3.2 percent of women surveyed by UNAIDS after the war reported being raped—over

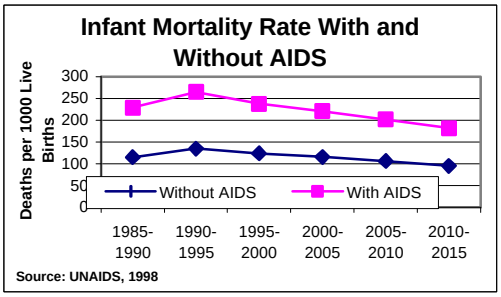
> *"When men are told they are HIV-positive," says Dr. Maria Neira, a UN volunteer who was a physician for the local and expatriate community of the United Nations system in Kigali, "some get very angry and deliberately sleep with as many women as they can to contaminate them."*

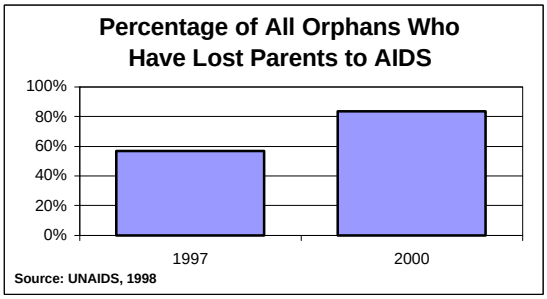
half of them during the conflict itself. Rape was used as a weapon and means of humiliation of women during the 1994 conflict. Women who reported rape were three times as likely to have suffered from genital sores and other symptoms of the STIs that increase the efficiency of HIV transmission. Seventeen percent of the women who had been raped were HIV-positive, compared with 11 percent of those who had not been raped. Thirty eight percent of rape victims were in the 12-19 year age group.

Children and HIV/AIDS

The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality among infected children and orphaning many others. High rates of mother to child transmission have caused Rwanda to counsel mothers against breast-feeding. This is a painful decision in light of the country's high infant mortality rate.

- Approximately 30 to 40 percent of infants born to HIV-positive mothers in Rwanda and other African countries will also become infected with HIV.
- During the next 16 years, AIDS is expected to increase Rwanda's already high infant mortality rate (130 per 1,000 live births) by 10 percent.
- In 1997, 21% of all pediatric patients, and 60% of those with malnutrition in the Kigali Central Hospital were HIV positive.
- At the end of 1997, there were 94,000 AIDS orphans living in Rwanda.
- By the year 2000, nearly 60 percent of all Rwandan orphans will have lost their parents to AIDS. In 2010 that percentage will rise to over 80 percent.





Youth and HIV/AIDS

Sixty percent of the total Rwandan population is younger than 20. The Ministry of Health estimates that the HIV prevalence rate among the sexually active population under age 20 was almost 10 percent in 1997.

The adolescents of both sexes who had not gone to school had higher prevalence rates than those who had attended school. Girls aged 12-14 years who had not received education had a rate of 9.4% in contrast to 5.0% among those who had attended school.

- Four percent of Rwandans ages 12 to 14 are already infected with HIV.
- Among 15- to 19- year-olds, HIV prevalence is actually higher in rural areas (8.5 percent) than in cities (3.4 percent).
- In a post-war survey conducted by UNAIDS, two out of five rape victims were teenagers.

Socioeconomic and political Effects of HIV/AIDS

The HIV/AIDS epidemic will have a severe impact on the economy and society of a country already overburdened with debt and the bitter legacy of a genocidal civil war. It threatens Rwanda's food supply, trade, and future development, as well as the health and well-being of its people. The ILO estimates that only 52% of Rwandans are economically active. AIDS will be most prevalent among this most productive group.

HIV has potential for implications for political stability. In many instances, the spread of HIV/AIDS is a part of a crippling cycle affecting leadership and governance. Civil strife, refugee flows, urbanization, and poverty all play a role in creating conditions conducive to the rapid spread of HIV/AIDS.

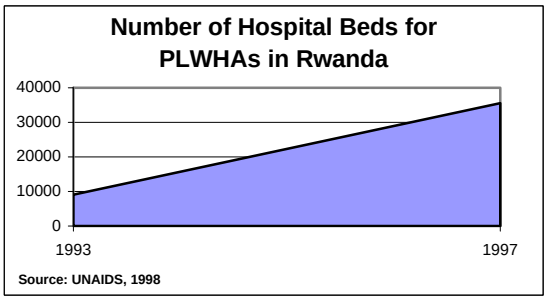
The high HIV/AIDS infection rates in the military personnel of the country including officers as well as enlisted personnel, will result in national security threats as military command structures are diminished and depleted by the disease. A 1998 UNAIDS report entitled "AIDS and Military" states that military HIV infection rates in the country are three to four times higher than in the civilian population. A strong correlation found between rank and prevalence rates indicated that as the disease progresses, the military will suffer from debilitated leadership and inability to meet military needs and commitments. The Rwandan military is currently developing a three-year action plan to combat AIDS in collaboration with the Ministry of Health.

HIV/AIDS can deal a crushing blow to families struggling to survive. Nearly all of Rwanda's population is engaged in subsistence agriculture, yet with the limited land per family in this densely populated country, more than half of these households do not produce enough for their families. Chronic malnutrition has become endemic. One USAID-supported study found that about 30 percent of children in several age groups were either moderately or severely malnourished.

Ministry of Health studies have shown that the income of a family drops significantly when one or both parents are infected with HIV. Families are forced to sell or lease their homes, and some are unable to afford food and other necessities. In a 1996 study, 20 percent of HIV-positive people surveyed reported having reduced food resources. This percentage is like to increase as more and more HIV-positive people develop AIDS.

Rwanda's healthcare system is also poorly equipped to cope with the effects of the epidemic. In 1998, 2.7 percent of the recurrent budget (0.3 percent of the GDP) was spent on health—a percentage expected to rise to 4 percent of the recurrent budget in 1999. Forty-three percent of the country's health expenditure is financed by the government, 38 percent by external aid, and 22 percent by the general population.

The number of hospital beds occupied by people living with HIV/AIDS (PLWHA) rose from 9,000 in 1993 to 35,600 in 1997. This accounts for an estimated 50% of hospital capacity occupied by AIDS-related cases.



As HIV/AIDS epidemic increases, the number of patients will overwhelm the healthcare systems leading to an increase in total national expenditure both in absolute terms and as a proportion of the national product. The net effect will be to increase the price and reduce the availability of health care to everyone, which will tend to affect the poor the most.

Interventions

National Response

In 1986 Rwanda's Ministry of Health created a National Commission for AIDS and developed an intensive HIV/AIDS education campaign in collaboration with the Rwandan Red Cross.

In February 1987 the Rwandan government, in cooperation with the World Health Organization's (WHO) Global Programme on AIDS, developed the First Medium Term plan (MPTI) for the prevention and control of the disease. The First Medium Term Plan (1988-1992) targeted blood transfusion safety, preventive health education, and epidemiological surveillance. The program was well established, with both external and internal support.

In the post-crisis period, the Ministry of Health renewed its commitment to decentralizing the health care system, and the government made HIV/AIDS prevention a priority in all its economic and public investment programs. In addition to preventing HIV, the challenge for the Second Medium Term Plan (1993-1997) was trying to minimize the socioeconomic impact of AIDS on affected individuals and families.

In 1997 the Ministry of Health restructured the Programme National de Lutte Contre le SIDA (PNLS) to act solely as a coordination and research body. Planning, resource management, and service delivery are the responsibility of health districts. Decentralization of these functions should make STI and HIV services available to rural populations for the first time, but the availability and quality of these services remains limited.

Today HIV/AIDS is considered a national priority. There is a strong commitment at the highest levels of government, as well as the church, to openly talk about HIV/AIDS as a national tragedy.

The overall Ministry of Health budget received a 23 percent increase in 1999, with a particular emphasis on HIV/AIDS. The PNLS recently finished its three-year strategic plan for 1999-2001, as well as a national HIV/AIDS prevention and communication strategy. Priority areas of the national strategic plan are to:

- Maintain 100 percent safe blood transfusion.
- Reduce STI prevalence among the general population and at-risk groups, including the military, truck drivers, and sex workers.
- Reduce vulnerability to HIV and other STIs.
- Reduce the number of people who depend on sex for their livelihood.
- Provide voluntary counseling and testing (VCT) services.
- Strengthen care and support services for PLWHA and orphans.
- Mobilize and support nongovernmental, religious, and community-based organizations to implement HIV/AIDS and STI activities.
- Reduce mother-to-child transmission of HIV.

Donors

Many multilateral and bilateral donors are actively engaged in HIV/AIDS programs in Rwanda (see next page). To reduce HIV transmission, USAID has been working collaboratively with UNAIDS, WHO, UNICEF, and the Belgium Cooperation.

Organization	Amount US$ 1996-97
Germany (period covered unknown)	4,700,000
USAID	3,000,000
Luxembourg	1,300,000
EU	1,000,000
Belgium	800,000
Total	**10,800,000**

Bilateral organizations' contributions

USAID has supported HIV/AIDS activities since 1993. USAID/Rwanda was the first bilateral mission to resume development programming in the country in 1994, through Family Health International's AIDS Control and Prevention (AIDSCAP) Project. Prompt USAID assistance in the health sector made it possible to re-establish the national HIV/AIDS program and launch HIV and STI prevention, education, and social marketing activities throughout the country in the post-war period. In March 1997, USAID initiated a transition plan in which emergency relief was scaled down and development assistance focused on rebuilding capacity in the health, justice, and agricultural sectors. One million dollars was dedicated to HIV/AIDS activities in FY 1997. USAID's FY1999 budget for HIV/AIDS activities is $3,000,000.

USAID/Rwanda is working to increase the use of health services and change behaviors related to HIV/AIDS, STIs, and maternal-child health. HIV/AIDS activities in the mission's integrated plan for 1997-1999 include:

- Technical assistance to regional and district medical teams to plan and manage the integration of HIV/AIDS and STI services into existing health services.
- Development of tools, methodologies and materials to improve the quality of services.
- Training.
- Support for regional assistance to local programs, including community-based education and awareness raising.
- Continued support to a nongovernmental organization (NGO) to develop a sustainable model for peer education in one region that will be replicable in other regions.
- Funding programs through church organizations within the country to educate young children and the youth on how to prevent the transmission of HIV/AIDS.
- The USAID AIDSMARK in collaboration with the World Bank and the Ministry of Health are helping to establish a local non-profit NGO managed by Rwandans (The Rwanda Center for Health Communications). The services of the center will be the design and production of education materials to prevent the spread of HIV/AIDS.

UNAIDS has a coordinating theme group based in Rwanda. The group, chaired by WHO, includes representatives from UNDP, UNICEF, UNFPA, the World Bank, and UNESCO and the Director of the PNLS. Support from UNAIDS cosponsors in 1996-97 included:

Organization	Amount US$ 1996-97
World Bank	18,600,000 *(June 1996-July 1998)*
UNFPA	2,100,000
UNICEF	1,500,000
UNAIDS	100,000
UNDP	609,000 *(96 only)*
WHO	41,000 *(96 only)*
Total	**22,950,000**

The World Bank has not made any direct loans for HIV/AIDS to the Rwandan government**.** However, the World Bank, in collaboration with the International Monetary Fund, has been one of the major donors for overall health sector reform. A project funded by these two organizations aims to (a) improve the efficiency of the national private health system and (b) expand use of health services, including those in support of national population and nutrition strategies.

Rwanda is currently the headquarters of the Great Lakes AIDS Initiative (GLAI), an initiative to combat the spread of HIV/AIDS along the trade routes in the Great Lakes area.

Private Voluntary Organizations (PVOs) and Nongovernmental Organizations (NGOs)

A number of PVOs implement activities funded by multilateral and bilateral donors. Some of the major USAID cooperating agencies include Family Health International, CARE, and Population Services International. NGOs also receive funding from a variety of sources and conduct most of HIV/AIDS prevention and care activities in Rwanda.

FHI's IMPACT Project is providing capacity building in regions in the area of STI management, and assisting in the coordination of local NGOs working in the area of HIV/AIDS prevention.

In April this year, the Rwandan government started a program of anti-viral triple therapy for patients with AIDS. The government imports the medicines and the patients pay for it. Treatment costs RWF 180,000 per month ($475.00) for the triple drug therapy. The annual income per capita for an average Rwandan is $210.00. This option is therefore beyond the means of all but a tiny fraction of the population. At present, only 140 wealthy Rwandans are following this therapy. Patients are kept on AIDS medication as long as they remain alive.

Through a UNICEF sponsored project, pregnant women are given AZT at no charge in order to prevent vertical transmission to the unborn child. The Ministry of Health has expressed interest in initiating other preventive therapy at the time of labor, following encouraging trial results in Uganda.

Challenges

Major constraints to HIV/AIDS control in Rwanda include:

- *More immediate threats*. In the wake of the constant threat of violence and in the midst of a daily struggle to subsist, it is difficult to convince people to care about a disease that takes years to develop.
- *Inability to discuss and distribute condoms*. Although the church has accepted the responsibility to speak against HIV/AIDS to their flock, it is reluctant to support programs that distribute condoms.
- *Impact on women*. The importance of Rwandan women as the main source of family stability and nutrition makes them especially vulnerable to economic pressure to trade sex for money or food. The situation is compounded by the fact that, there is a large number of widows of the 1994 genocide who engage in having multiple sexual partners in order to find social security and to replace their dead children.
- *Lack of literacy*. Although universal use of the language *kinyarwanda* eliminates some of the communication difficulties encountered in other countries containing many ethnic groups, illiteracy is a major constraint to HIV/AIDS education. Almost three-fourths of the country's women and more than half the men are estimated to be illiterate.

The following gaps in programming must be filled in order to mount an effective response to HIV/AIDS in Rwanda:

- Household food security is essential if Rwanda is to achieve peace and stability. Without it, people will continue to struggle over a fragile resource base, and conflict will continue.
- Long-term government policy should address the underlying causes of health problems, including inadequate housing, sanitation, water, and nutrition.
- Measures are needed to ensure a safe and sufficient blood supply.
- Legislation and enforcement are required to protect the human rights of PLWHA.
- Rwanda needs training, technical assistance, and resources in order to meet the increasing demand for voluntary HIV counseling and testing.

The Future

It is not too late for an effective response to the HIV/AIDS epidemic in Rwanda. The USAID is currently providing leadership role in its support to the Rwandan ministry of health in the fight against HIV/AIDS. Also NGOs churches, women's groups, businesses, microenterprise, and community groups have shown that they can play an important role in HIV prevention and care. With additional financial and technical assistance, these groups could be mobilized to expand proven interventions on national scale.

Important Links and Contacts

1. UNAIDS Country Programme Advisor
2. PNLS

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April 1999

U.S. Based
Institutional Interventions

Rwanda

Organization	Intervention																
	Advoc.	BCI	Care/S	Training	Cond.	SM	Eval.	HR	IEC	MTCT	Research	Policy	STD	VCT	Orphan	TB	Other
Cooperating Agencies																	
FHI/IMPACT		X		X			X		X		X	X	X				Capacity building
PSI					X	X			X				X				
PVOs/NGOs																	
CARE		X		X	X	X	X		X			X	X		X		
World Relief	X	X		X					X			X			X		
Doctors Without Borders		X	X	X					X								
Salvation Army			X		X				X						X		

KEY:

Advoc.	Advocacy	**MTCT**	Mother to Child Transmission activities
BCI	Behavior Change Intervention	**Research**	HIV/AIDS research activities
Care/S	Care & Support Activities	**Policy**	Policy monitoring or development
Training	HIV/AIDS training programs	**STD**	STD services or drug distribution
Cond.	Condom Distribution	**VCT**	Voluntary counseling and testing
SM	Social Marketing	**Orphan**	AIDS orphan activities
Eval.	Evaluation of several projects	**TB**	TB control
HR	Human Rights activities	**Other**	(I.e. blood supply, etc.).
IEC	Information, education, communication activities		